Twenty Questions and Answers on

A System for Universal Health Care

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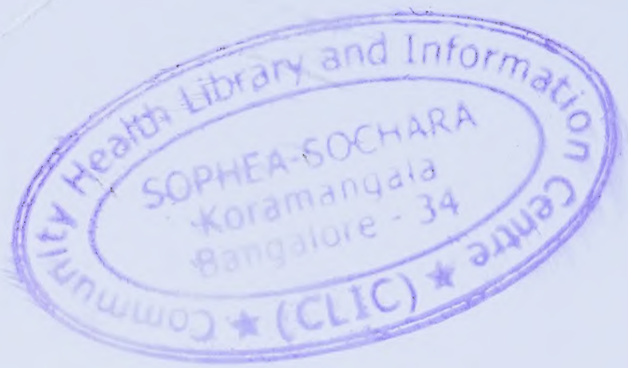
How can we hope to achieve it?

SATHI

(Support for Advocacy and Training to Health Initiatives)



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A System for Universal Health Care

What is it? And how can we hope to achieve it?

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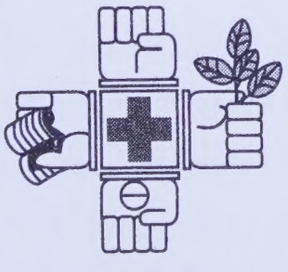

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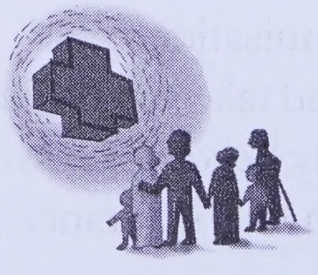
Introduction

Various pro-people bodies working on health issues like Jan Swasthya Abhiyan have been advocating since many years to ensure 'Health and Health Care for All' in India. There has not been much positive response from the State so far to this demand. However, during the recent period, several opportunities as well as threats have emerged in the health care scenario in India. Given the background of weak and under-resourced public health services combined with dominant, often unaffordable and irrational private medical care, there is a tremendous social need to bring in a system which would ensure access for all to appropriate and good quality health care. In this context, now proposals for universalising access to health care are emerging on the national agenda. At the level of civil society organisations, Medico Friend Circle has been debating and working out possible directions for a system for 'Universal Access to Health Care' (UAHC), while at official level, in October 2011, the High Level Expert Group (HLEG) of the Planning Commission has submitted its report on 'Universal Health Coverage'. Based on this setting, we feel that it is relevant for health professionals, health activists and socially concerned persons to understand some of the key concepts related to UHC, so that many more people can meaningfully and actively contribute to the ongoing debates and discussions. Considering the fact that differing 'versions' of UHC are in circulation, which have widely different implications for the future of the health system in India, it is very important that pro-people networks, organisations and individuals understand the nuances of this issue and take stands that would ensure that UHC in India does not primarily become an avenue for further profiteering by the corporate health and insurance sector, but instead of that a

'public-centred' vision for Universal Health Care is actualised in the coming period. Keeping in mind this situation, SATHI is publishing this booklet which it hopes, will help activists and interested persons in understanding some basics of this important theme.

A SATHI team (Drs. Anant Phadke, Abhay Shukla, Nilangi Sardeshpande) conceptualized, planned and steered the preparation of this booklet including incorporation of comments from the reviewers and preparing the final draft. The basic draft of this booklet has been ably prepared by Dr. Amita Pitre, who collated information from a wide variety of sources to present this complex topic with a pro-people perspective, in intelligible form. Dr. Abhijeet More of SATHI has helped in obtaining feedback on the draft. We are grateful to Renu Khanna, Dr. Indira Chakravarthi and Ravi Duggal who have provided several useful suggestions as reviewers, while of course the views expressed in the final booklet remain the responsibility of the publishers. Sharda Mahalle has capably done the layout and design of the booklet to prepare it for publication. We would like to acknowledge the many discussions in Medico Friend Circle and Jan Swasthya Abhiyan over the last few years on the theme of 'Universal Access to Health Care/Health Care for All' which have informed many of the views and analysis presented in the following pages, and hope that this booklet would be a small contribution towards the massive task of ensuring 'Health and Health Care for All' in India.

Abhay Shukla
SATHI



Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
ART	Anti Retroviral therapy
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy
BPL	Below Poverty Line
CBMP	Community Based Monitoring and Planning
CHW	Community Health Worker
DHKI	District Health Knowledge Institute
ESIS	Employees State Insurance Scheme
FCC	First Contact Care
GDP	Gross Domestic Product
GNI	Gross National Income
HCA	Health Care for All
HFA	Health for All
HIV	Human Immunodeficiency Virus
HLEG	High Level Expert Group
HRH	Human Resources for Health

JSA	Jan Swasthya Abhiyan
NGO	Non Governmental Organisation
NCHRH	National Council for Human Resources in Health
NHS	National Health System
NHSO	National Health Security Officer
NSSO	National Sample Survey Organisation
PPP	Public Private Partnership
PRC	People's Republic of China
RRT	Renal Replacement Therapy
RSBY	Rashtriya Swasthya Bima Yojana
SATHI	Support for Advocacy and Training to Health Initiatives
UAHC	Universal Access to Health Care
UHC	Universal Health Care
WHO	World Health Organisation

Contents

The accident happened on 7th October 2006. Narin fell off his motorcycle going into a bend. He struck a tree, his unprotected head taking the full force of the impact. Passing motorists found him some time later and took him to a nearby hospital. Doctors diagnosed severe head injury and referred him to the trauma centre, 65 km away, where the diagnosis was confirmed. His skull had fractured in several places. A scan showed that his brain had bulged and shifted, and was still bleeding; the doctors decided to operate. He was wheeled into an emergency department where a surgeon removed part of his skull to relieve pressure. A blood clot was also removed. Five hours later, the patient was put on a respirator and taken to the intensive care unit where he stayed for 21 days. Thirty-nine days after being admitted to hospital, he had recovered sufficiently to be discharged.

What is remarkable about this story is not what it says about the power of modern medicine to repair a broken body; it is remarkable because the episode took place not in a 'developed' or 'rich' country, where annual per capita expenditure on health is very high, (close to US$ 4000 or Rs 1,92,000/), but in Thailand, a country that spends only about 1/30th of this amount (US$ 136 or Rs 6528/-) per capita on health. For Thailand, this amounts to just 3.7% of its gross domestic product (GDP). Nor did the patient belong to the ruling elite, the type of person who tends to get good treatment wherever they live. Narin was a casual labourer, earning only US$ 5 (or Rs 240/-) a day.

"Thai legislation demands that all injured patients be taken care of with standard procedure no matter what their status," says the surgeon who operated on Narin. The surgeon further clarified that medical staff do not consider who is going to pay for treatment, however expensive it might be, because in Thailand, everyone's health-care costs are covered.

(Source: WHO, 2010, The World Health Report, Financing for universal coverage)

What does it mean when Narin's surgeon says 'everyone's health care costs in Thailand are covered or already paid for?' Is it possible to pay for health care in advance and not have to pay while seeking care? And who pays for it when the surgeon says 'it is paid for'? Was the hospital being referred to public or private? Is it possible that doctors will directly start treatment without asking for an advance in a private hospital? What does the WHO report refer to as 'Universal Coverage'? Is this possible in India?

Many such questions are frequently asked when we discuss and debate the question of making health care accessible to all under our vision of 'Health for all'. This booklet is meant to-

- Clarify some key concepts around systems for 'Universal Health Care' (UHC)
- Discuss briefly where and how these concepts have been put into practice
- Examine the tangible benefits of such a system
- Discuss whether we could develop such a system in India; look at the legal and policy framework and financial commitments required for this

The readership for this booklet is anyone who is interested in making health care accessible and affordable to all. The booklet unfolds in the form of answers to some frequently asked questions.

1. What exactly do we mean by a system for 'Universal Health Care[1]' (UHC)?

By a system for 'Universal Health Care' is meant a system which functions with the principle and objective of providing the entire population of a country good quality health services according to needs and preferences, regardless of income level, social status, or place of residence[2]. The 'System for Universal Health Care' should be part of the broader goal of achieving 'Health for All'.

As a mechanism to *'raise the standard of living and of public health'* it is the duty of the state to provide health care to the people as outlined in the directive principles of the constitution of India[3].

The term Universal denotes 100% coverage of the population. Every citizen and resident of the country is covered by the respective services without any targeting. Such a system serves not only those 'Below Poverty Line' but includes the entire spectrum of rural and urban poor as well as middle class and well off sections of the society.

In a system of System for Universal Health Care, services would be as follows -

- **Good quality services** that would include a comprehensive package of primary and secondary, tertiary health care, emergency health care and commonly required preventive, promotive, curative and rehabilitative services for a healthy life. In the first stage of its

[1] The terms Universal Health Care, Universal Health Coverage and Universal Access to Health Care are often used interchangeably. But it should be noted that from the point of view of the People's Health Movement, it's not merely a question of extending the existing health care system but of transforming it to a new system which is geared towards the objective of availability of health care as a right and not as a commodity. Hence in this booklet we have preferred the term – 'System of Universal Health Care'.

[2] Nitayarumphong, S. (1998). Universal coverage of health care: challenges for the developing countries. In Nitayarumphong, S., and Mills, A. (Eds.) Achieving universal coverage of health care. Nonthaburi: Office of health care reform, Ministry of Public Health.

[3] Article 47, Directive Principles of State Policy, Constitution of India, Part IV

implementation, the health services package in UHC may not cover certain health care services. This is a little complex, sometimes grey area. For example, certain very expensive treatment options may or may not be included in UHC. (See answer to question no. 11) Costly cosmetic surgery for 'beautification' (like hair transplant in case of baldness or 'liposuction procedure' for cosmetic purposes as distinct from restorative 'plastic' surgery after say burns/traumatic injuries etc) would not be made available. Those services which the society can afford to make available to ALL the people needing these services will be part of the UHC package. However every attempt must be made to include all important treatment options within the fold of UHC making them accessible to all.

- **According to needs and preferences** means that all the people needing services would be covered and that the neediest will be prioritised. Secondly, people will have reasonable choice about their treatment options such as-

  - Whether to take treatment from an AYUSH[4] provider or allopathic provider.

  - Choice between various available doctors belonging to the same specialty within the same hospital

  - Choice between a range of therapies available for that ailment in the given framework

- **Regardless of income level** means irrespective of the ability to pay. Even the poorest will be able to access this package of services.

- **Regardless of social status** means marginalised social groups such as dalits, adivasis, minority communities or other vulnerable groups such as single or deserted women, orphans, elderly, disabled, migrants and others will have equal access to this package of health care.

[4]AYUSH stands for Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy. It is used to denote the Indian Systems of medicine as against allopathic or `western' medicine.

- **Regardless of place of residence** means the current gross inequality between urban and rural areas has to be overcome to give good care to all the needy people, including those in rural and remote areas.

2. Why is it necessary to have a system for universal access? What are the problems with our current health care system?

In the current health care system in India-

i. The majority i.e. 80% of out-patient care and 60% of in-patient care is provided by the private medical sector. There are practically no controls or checks and balances regarding the quality or price of these private services.

ii. The network of public health services is presently deficient in availability and quality of services as well as as regards sensitivity and accountability to the patients. Due to problems of insufficient funding, and being under-staffed, under-equipped, it is quite inadequate to cater to the needs of the entire population – rural and urban, poor and well off.

iii. In the private sector and, now partly also in the public sector, patients have to pay from their own pockets for health services.

The consequences of this, especially for those who cannot pay are-

a) Impoverishment on account of health care

- According to NSSO (60th round), in 60% of hospitalisations in rural areas and 42% hospitalisations in urban areas, the households had to borrow money or seek contribution from friends & relatives or sale ornaments and other physical assets to meet the hospitalisation related expenses[5].

[5] National Sample Survey Organisation. (2006). Morbidity, Health Care and the Condition of the Aged (NSS 60th round). New Delhi: Ministry of statistics and programme implementation, Government of India.

• Every year about 33 million Indians are pushed into poverty due to health care expenses[6].

b) Extreme inequities in access to health care

• There are massive inequities in health service availability across the country and across social classes. For example: urban areas have several times more doctors, nurses, hospitals and hospital beds (both public and private) per thousand population, than do the rural areas. Some states in India have woefully inadequate number of medical colleges, nursing schools, hospitals or specialist doctors while others have more than their requirements. The poorest section of Indians is two and half times more likely to forego medical treatment as compared to the richest. These inequities in access to health care are growing and are adding to the larger social and economic inequities in the country.

c) Irrationalities and wastages

Another aspect of our unregulated and largely privatised healthcare setup is irrational and wasteful care. To give an example, caesarean section rates among the rich women are 17 times higher as compared to poor women; nearly 12 times higher among educated as against non-literate and 3 times higher among the urban women as compared to rural women[7]. The rich, urban and educated women are undergoing irrationally high number of Caesarean sections while the poor, rural and non-literate women many a times do not have access to essential caesarean operations even when genuinely needed.

Similarly studies have shown irrationally high use of unnecessary injections[8], irrational and varied treatment regimens for

[6] Ministry of health and family welfare, India. (2005). Report of National commission on macroeconomics and health. Government of India.

[7] International Institute for Population Sciences (IIPS) and Macro International. 2007. National Family Health Survey (NFHS-3), 2005–06: India: Volume I. Mumbai: IIPS.

[8] Assessment of injection practices in India. (2005). INCLEN.

tuberculosis[9, 10], and high proportion of irrational and unnecessary[11] formulations among the most commonly used medicines in our country.

All this calls for organising a more affordable, equitable, rational and efficient health care system, all of which can be provided through a System for Universal Health Care.

3. Why are we talking about UHC today? Does it mean we are no longer talking about 'Health for All' or Right to improved public health services?

To answer the first question – In this booklet, UHC and 'Health Care for All (HCA)' are synonymous. Jan Swasthya Abhiyan, since it's inception in 2000, has been advocating in favour of 'Health Care for All (HCA)' as part of it's broader goal of 'Health for All' as enshrined in the Alma Ata Declaration. It should be noted that the Alma Ata Declaration has a much better, broader framework of a New International Economic Order. The renowned concept of Primary Health Care as used in the Alma Ata declaration implies not only Primary Health Services ("the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work") but also an approach based on principles of inter-sectoral co-ordination between various sectors of the economy, of self-reliance, of community participation etc. JSA continues to adhere to this broader framework, while the term UHC and the discussions around it have emerged and spread relatively recently. This new discourse on UHC has a narrower object of extending

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[9] Uplekar, M.W., Shepard, D.S. (1991). Treatment of tuberculosis by private general practitioners in India. Tubercle, 72, 284–90.

[10] Uplekar, M., Pathania, V., Raviglione, M. (2001). Private practitioners and public health: weak links in tuberculosis control. Lancet, 358(9285), 912-6.

[11] Patel, V., Vaidya, R., Naik, D., Borker, P. (2005). Irrational drug use in India: A prescription survey from Journal of Postgraduate Medicine, 51, 9-12.

health-care coverage to the entire population. Hence it often focuses on financial measures rather than on a whole series of measures regarding improvements in the health-care system. Secondly unlike the Alma Ata Declaration it is concerned about only health care; there being no mention of 'health for all'. Thirdly, the content of this health care in UHC can mean different things to differing people compared to the well established meaning in the Alma Ata Declaration.

Despite these limitations, we have used the term UHC in this booklet because we need to engage with this UHC discourse and try to shape it in the direction of the discourse of Alma Ata Declaration. It should be clarified that we are using the term UHC not in the sense of merely increasing the coverage of the existing health care system but we are talking of a new, reorganised health care system which would ensure access to quality health services for all; the meaning of which would get progressively clarified as we proceed forward in this booklet.

In India, the UHC-discourse has been seen by the ruling coalition as a preparation for the next Lok Sabha election in 2014, the Prime Minister, Mr. Manmohan Singh has fostered the appointment a 'High Level Expert Group' (HLEG) by the Planning Commission to prepare a detailed report and recommendations for achieving UHC in India by 2020. It's final report[12] of October 2011 is likely to be considered while formulating the 12th Five Year plan. Given this background, it is necessary that various civil society organizations including JSA should put forth and propagate their views, and suggest an appropriate outline of a system for UHC/HCA. There is need to clarify the areas of convergence and divergence between the health movement perspective and other proposals for a system of UHC in India.

For example, for the People's Health Movement, the mission

[12]The Executive Summary is available at http://www.phfi.org/images/what_we_do/ hleg-uhcexecutivesummary_final.pdf

for 'Health Care for All' can not be isolated from the goal of HFA. Health for All includes:

- Universal provision of social determinants of health such as food security, nutrition, water supply, sanitation, healthy environmental conditions etc.
- Ensuring appropriate, quality health care to all, and
- Democratic, equitable and participatory processes to achieve these.

A system of UHC or 'Health care for all' is one important goal within this larger goal and is important to achieve 'Health for all' (HFA). The system of UHC definitely needs to be combined with improvement in various health determinants to move towards HFA. Secondly, as mentioned earlier, from the point of view of the People's Health Movement (PHM), UHC does not mean a mere achievement of Universal Health Coverage, meaning just increasing the 'coverage' of the existing system. It's not a question of just extending the coverage of the existing irrational system, but instead of building a new System for Universal Health Care by transforming the existing Public and Private Health Care Sectors.

Moving towards UHC would clearly require ***major strengthening, expansion and improvement of public health services, and the public health system would be the backbone of the UHC system***. Hence the demand for UHC takes to a higher level the demand for continued strengthening of public health services, rather than leading to any weakening or reduced attention to these services.

Annexure enlists the recommendations of HLEG and a summary of the assessment of these recommendations based on the discussion in JSA's meeting in Delhi on 21st-22nd March 2012 on this issue and subsequent JSA's press statement of 7th April 2012. ***At the end of this annexure, we have also reproduced the concluding section of the JSA statement of 7th April 2012 (World Health Day), on Universal Health Care.***

4. What is the overall aim and what are the objectives of the UHC system?

The overall aim of proposed UHC in India would be to provide good quality health services to all residents of India. At the same time health care providers should have job satisfaction, dignity and reasonable reward for work.

The important specific objectives are -

- To make a comprehensive set of health care services available to all, regardless of income level, social status, gender or area of residence

- To prevent impoverishment of people on account of health care expenses

- To reduce inequities in health care access across income and social groups, and across regions.

- To reduce wastages in providing health care, improve efficiency of the health system and promote rational health care

5. What would be the principles and core elements of the UHC system?

As we shall see later, there is no single method of achieving universal access. Various countries have used varying strategies - some more successful than others. Principles for any UHC system would be those core values which allow us to assess if progress is being made in the right direction. The following are such principles-

- **Universality:** As the name suggests, it is important that ALL residents of the country be covered under UHC. UHC should not be restricted to any population group such as only the formal employees, or those who can contribute towards it, or only those who are 'Below poverty line'.

- **Equity, non-exclusion and non-discrimination:** A UHC system should be fair and egalitarian. This means that it must be

available to all, irrespective of caste, class, ethnicity, gender and sexual orientation, but care for the medically most needy may be prioritised. The most needy will need to be suitably defined, such as those with more serious illnesses or where time-bound treatment, as in an emergency will make a huge difference.

- **Comprehensive care:** The range of services available in a UHC system should be as broad as possible to meet the entire range of healthcare needs, taking into account the local patterns of illnesses and needs of different sections of the population including those of the vulnerable sections. Every effort should be made to progressively increase the extent and spectrum of services and to include the use of cost-effective technology.

- **Financial protection:** UHC should guard against impoverishment of people on account of health care expenses.

- **Quality and rationality of care:** UHC should ensure prescribed quality and standards of care and follow guidelines for rational care.

- **Portability and continuity of care:** Treatment for an illness should not be discontinued if and when the patient changes residence- e.g. in case of migrant workers, pregnant women who decide to deliver at their natal homes etc. Emergency care must be available to all, including those who travel any wherever in the country. Referral and transport of patients needs to be properly organised, and there should be no gap in care when patients are transferred from one facility to another.

- **Protection of patients' rights, appropriate care, and patients' choice:** UHC should be designed to protect patients' rights such as right to information, informed consent, reasonable choice of a provider, appropriate care etc. A grievance redressal system should be in place in case the patient or care givers have complaints.

- **Participation, transparency and accountability:** This will ensure that people are involved at every stage of planning for the UHC; they will be informed and can ask questions, demand redressal of any grievances, and the system will be accountable to them.

- **Consolidated and strengthened public health provisioning:** Provision of services by strengthened public facilities would be at the core of the UHC system, and public agencies should play the coordinating role in demarcating the roles and responsibilities of all facilities, including the private sector, in provisioning under the UHC system.

- **Central role of Public financing:** The prime responsibility of financing the health care system should be with the state and through public financing, primarily general taxes. This would also mean that that the doctors, hospitals would be paid from a single pool of centralised fund and patients will not have to pay anything at the point of service. Health care is a human right and nobody should be denied health care on the grounds of inability to pay fees for health care. In all developed countries there is no payment or hardly any payment, to be made by the patient at the point of service. Most of the health care expenses are met through this central pool of funds. Such 'single payer mechanism' based on general taxation has certain advantages –

- It is far more equitable because the poor have as much right as the rich to get health care, though their contribution to taxes is lower.

- It is far more equitable across regions. People in underdeveloped areas have as much right as those in the developed areas to get health care though their contribution to taxes is lower.

'Single payer mechanism' lowers overhead costs of collecting money from citizens because the expenses required for collecting contributions from citizens at hundreds of places where they seek health care is avoided in this system.

These principles have been adopted by the above mentioned HLEG report also.

6. Has any country been able to ensure UHC for its people?

Yes, many countries have been able to ensure UHC for their residents. Most European countries have ensured UHC for their citizens during the last 60 years. Prominent examples are the National Health System of the United Kingdom, UHC models of Scandinavian and West European countries such as France, Germany and Netherlands. Healthcare systems of Canada and Australia are also other leading examples of UHC for all citizens among the non-European countries. USA is a notable negative exception where despite very high health care spending, citizens do not enjoy universal access to health care, and about 50 million (20 percent) of US citizens, do not have health care coverage.

7. The countries mentioned above are rich countries. Has any developing country been able to practice UHC? Has any country in Asia tried it out?

Yes, several developing and middle income countries have successfully made UHC available. Some of them in Asia are-

Thailand: Thailand introduced UHC in 2001. This Southeast Asian country with a population of 61.2 million and per capita gross national income (GNI) of 7,640[13] international dollars[14] in PPP terms (2009) has nearly 60% of its population residing in rural areas. It has a large private medical sector and majority of workers are in the informal sector. Their issues of health care access were similar to the ones seen currently in India. After the introduction of UHC in 2001, the population with no health insurance came down to only 1.3% by the year 2004. In 2006, the Thai government made access to UHC completely free of charge by abolishing the co-payment of 30 Baht which was required to be paid earlier to the doctor for every visit to

[13] GNI per capita in PPP terms for India is 3, 250 international dollars (2009). This is comparable to Philippines.

[14] Source for all GNI figures: http://siteresources.worldbank.org/DATASTATISTICS/Resources/GNIPC.pdf

the doctor.

Sri Lanka: Sri Lanka, with a population of about 20 million and per capita gross national income (GNI) of 4,720 international dollars in PPP terms started the expansion of a strong public health system as early as 1931, with the election of the first democratic government. This expansion was done by increasing the government's budget for health care. Today, Sri Lanka provides free primary and secondary health care including free medicines for all residents through the public health system. It also has a strong preventive and promotive health care component, excellent awareness of health rights and a very good public health response to emergencies as seen at the time of the Tsunami. As a result, various health indicators of this middle-income country compete with the developed countries. Sri Lanka has been able to achieve this by a public investment in health care, of 1.9% of its GDP and about 8% of its budget expenditure[15].

Republic of Korea, Malaysia and Philippines are other countries in Asia that have been able to institute a system for Universal Health Care and cover most of their population.

Some Latin American countries have also achieved UHC. Socialist Cuba achieved UHC within a few years of its revolution in 1962 entirely through public provision of health care.

Brazil is the fifth largest country in the world, with a population of 172 million and per capita gross national income (GNI) of 10,200 international dollars in PPP terms (2009). The 1988 Brazilian Constitution made access to healthcare a universal right and developed 'The Unified Health System', their national system to deliver primary healthcare. This system includes apart from all public facilities those private facilities which accept the terms of UHC, thus bringing private sector under public services. Prior to 1988, only the 60% of Brazilian families who worked and paid social security taxes

[15]Rannan-Eliya, R. P., Sikurajapathy, L. (2009). Sri Lanka : 'Good Practice' in expanding health care, Colombo: Institute for Health Policy.

had health insurance. Now, everyone in Brazil has the right to use any public health service in the country at no out-of pocket cost.

More recently **Venezuela** has achieved Universal Health Care through very effective systems of public provisioning focussed on Primary health care, in the context of broader radical socio-political changes. Even though the current political systems in some of the mentioned countries provide a very different context from the present situation in India, we can learn valuable lessons from their health initiatives.

8. What are the requirements to establish UHC in any country?

Providing UHC needs careful planning on many fronts. Some of these fronts are-

- **Legal mandate-** Most developed countries and many developing ones with UHC have some form of legislation which mandates the state to provide health care to all. Some example are –
  - The Canada Health Act of 1984,
  - 'Unified Health System' in Brazil incorporated in the new constitution of 1988
  - 'National Health Security Act' of 2002 in Thailand

Such legislation greatly protects people's right to health care and ensures that even if successive governments change health policy, they cannot erode the UHC system.

- **A system for financing the UHC system-** A plan to generate revenue, estimate the budget requirements for various services, allocation of funds to facilities and projecting future financial requirements, all these constitute the financing of UHC. This is an important requirement for instituting UHC. It includes important policy decisions such as - How will funds be procured for providing services to all citizens? Will it be mainly tax based or would there be some mandatory contributory social insurance, especially

for the organised sector? If yes, to what extent and who would pay what proportion? Should a single payer mechanism be adopted? How will it function?

• **A system for provision of services-** All successful UHCs have a coordinated system for provision of services, with well defined roles for the public and private sector health care providers. Developing this system would include key policy decisions such as- What would be the role of a strengthened public health system and how would regulated private providers be involved? How will an integrated National health system take shape?

• **A system to regulate services-** This involves policy decisions regarding important concerns of consumers, such as - How would standards in health care be achieved and maintained? What happens if I don't get the promised care? How will wasteful, unnecessary and irrational care be curbed?

It may be however noted that the above countries differ somewhat from each other in how they have legally mandated, financed, provided for, and have regulated UHC.

9. What would be the specificities of UHC in a developing country like India?

There would be two specificities of the UHC system in a developing country like India.

Firstly there will be ***significant role for Community Health Workers*** (CHWs). CHWs are needed both in the developing and developed countries in three kinds of situations –

a. ***Where 'Doctors are not needed'*** (for example, giving initial, First Contact Care (FCC) in simple situations like minor injuries, simple diarrhoea, cough, fever etc.)

b. ***Where 'Doctors may not be the best option'*** (for example, empathetic counselling of a victim of domestic violence or advocating patients' rights in a hospital)

c. ***'Where there is no doctor'.*** This situation exists in many areas

in developing countries and is likely to continue for coming some decades; CHWs would be needed especially in some less accessible, rural areas.

Amongst a range of roles that CHWs can play, which specific roles would be emphasised more or less would vary in different parts of the country. In a remote, backward area CHW's role as providers of ***First Contact Care (FCC)***, would be essential; less so in other rural areas and peri-urban/urban areas. This is partly because of the fact that in these areas, doctors are easily available even for minor ailments and now people in these areas are used to seeking care from doctors even for First Contact Care. The role of ***CHWs as health-educators*** for healthy life style, ***as counsellors, as patient-advocates*** would be proportionally more important in more developed areas. It may be noted that in developing countries like India, certainly there is the opportunity and need to move away from a doctor-centric/hospital centric approach to a ***'health team approach'*** in the UHC framework.

Secondly in India in UHC, there should be ***inclusion of AYUSH systems of healing as an option at every level of health care:*** from self-care to village based care to hospital based care, as was done in People's Republic of China (PRC). So far in India AYUSH systems have received discriminatory treatment from the government. However, AYUSH should have a rightful place in UHC. This would consist of provision at all levels of AYUSH measures that are effective and safe; such provisioning would enable us to move towards an integrated approach to health care.

10. What mode of financing has been used in UHCs? Can private health insurance be the basis of UHC?

The two main routes to finance UHCs are through taxes and social health insurance.

• **Generating revenue through direct and indirect taxation-** This is the most cost-effective and equitable means of

raising finances for UHC. It is cost-effective because it requires minimal administrative mechanism. It is equitable because, direct taxation is generally in proportion to income and thus more contribution is collected from the higher income groups. For example in Thailand and Brazil general tax funding makes up a higher share of the financing for UHC and is thus a more progressive arrangement.

India has used special tax as a method to finance certain essential services, e.g. an education cess of 3% is applicable on all taxable commodities in order to finance primary education. Higher taxes for luxury items and taxes on disease causing items like tobacco, alcohol which are inherently deleterious to health can also enhance resources for UHC.

- **Social Health Insurance-** In a typical health insurance scheme, all those who are enrolled, pay a premium in advance. Then the bills of those who do fall ill are paid (upto an upper limit) through this pool of funds created through advance payment. In any insurance mechanism, the social risk of falling ill and need for medical treatment, is pooled on a mandatory basis among a group. Finances are generated through 'pooling of contributions' from a particular group such as employers and employees in an industry, specific occupation groups or geographic area groups.

Social Health Insurance, Private Insurance and Community Health Insurance are some methods of insurance. Of these three, Social Health Insurance is more progressive, equitable and inclusive in nature. Countries such as Germany in Europe and Japan and Republic of Korea in the Asia-Pacific region have a social health insurance based UHC[16]. On the other hand, *there is no comprehensive UHC system in the world based on private insurance or community based insurance alone.*

[16] Among other countries following the SHI model are Austria, Belgium, Costa Rica, Israel and Luxemburg

Countries that have UHC systems based on social health insurance generally have a single social insurance fund covering almost the entire population, where contributions from employers, employees, the self-employed and the government (on behalf of the unemployed and vulnerable sections) are pooled. In this system, the government steps in to contribute for those who do not have the resources to pay insurance premiums. Social Health Insurance works better than other forms of insurance also because the pool is very large thereby allowing cross-subsidising across groups. If the rich and poor groups (thereby also the more and less healthy respectively) form part of different pools, cross-subsidising cannot take place. This generally tends to happen with private insurance mechanisms.

Though more progressive than private insurance, Social Health Insurance based health care is generally less cost-effective and less equitable than tax financed options and is associated with greater administrative costs.

Regarding private health insurance ...

In no country of the world has private health insurance been the primary basis for comprehensive UHC. Some countries, such as the United States, use mainly private insurance, but this results in major problems and a large section of the population is not covered or is inadequately covered by insurance. Experience has shown that private insurance is a regressive form of insurance because-

- Profit maximisation is the stated goal of the private insurance companies. This leads to a tendency to minimise claim payments, even if there are legitimate medical expenses.

- There are multiple companies / providers and schemes. Therefore the health system is fragmented and it is difficult to regulate or make guidelines for the system. It is supposed that operation of the 'market' will ensure fair distribution of services and reduction in costs, however it is well known that leaving provision of social goods to the market often fails to ensure equitable and universal access.

- Due to multiple providers and litigation due to rejected claims, the administrative costs, litigation costs, inefficiencies and wastages of the system are very high.

Private insurance is presently used by some UHC systems in a marginal and supplementary form to finance cosmetic care, non-essential dental and ophthalmic care, and perks such as private rooms in hospitals. However it is clear that private / commercial insurance cannot become the basis of a comprehensive UHC system.

Financing of UHC in India : HLEG recommendations

The HLEG has made the following recommendations as regards financing of UAHC in India – (emphasis added. For other recommendations of HLEG pl see annexure I.)

3. 1 Health Financing and Financial Protection

3.1.1: Government (Central government and states combined) should increase public expenditures on health from the current level of 1.2% of GDP to at least 2.5% by the end of the 12th plan, and to at least 3% of GDP by 2022.

3.1.2: Ensure availability of free essential medicines by increasing public spending on drug procurement.

3.1.3: Use general taxation as the principal source of health care financing – complemented by additional mandatory deductions for health care from salaried individuals and tax payers, either as a proportion of taxable income or as a proportion of salary.

3.1.4: Do not levy sector-specific taxes for financing.

3.1.5: Do not levy fees of any kind for use of health care services under the UHC.

3.1.6: Introduce specific purpose transfers to equalize the levels of per capita public spending on health across different states as a way to offset the general impediments to resource mobilisation faced by many states and to ensure that all citizens have an entitlement to the same level of essential health care.

3.1.7: Accept flexible and differential norms for allocating finances so that states can respond better to the physical, socio-cultural and other differentials and diversities across districts.

3.1.8: Expenditures on primary healthcare, including general health information and promotion, curative services at the primary level, screening for risk factors at the population level and cost effective treatment, targated towards specific risk factors, should account for at least 70% of all healthcare expenditure.

3.1.9: Do not use insurance companies or any other independent agents to purchase health care services on behalf of the government.

3.1.10: Purchases of all health care services under the UHC system should be undertaken either directly by the Central and state governments through their Departments of Health or by quasi-governmental autonomous agencies established for the purpose.

3.1.11: All government funded insurance schemes should, over time, be integrated with the UHC system. All health insurance cards should, in due course, be replaced by National Health Entitlement Cards. The technical and other capacities developed by the Ministry of Labour for the RSBY should be leveraged as the core of UHC operations – and transferred to the Ministry of Health and Family Welfare.

11. What is the spectrum of services which countries make available to their citizens under UHC?

Most countries following UHC provide primary and secondary health care, emergency health care and a range of higher level medical, surgical and maternity services required by citizens to lead a healthy life. Often this package is progressively expanded based on budgets available, demands from patients, when neglected problems get highlighted, and based on progress in medical technology.

Some of the services excluded in some countries are-

- **Very expensive services-** e.g. Thailand had excluded 'Renal Replacement Therapy (RRT)' (commonly called 'Dialysis') from the UHC package. This was because of the extremely high costs of the service. In 2008, under growing pressure from patient groups, RRT has been included in the universal access scheme.

- **Cosmetic, Dental and Ophthalmic procedures-** Most UHC systems exclude cosmetic surgeries, unless they have an explicit rehabilitative role - e.g. plastic surgery after extensive burns would be included in UHC but a 'nose job' merely for enhancing natural looks would not be. Many UHCs ask patients to contribute for dental and ophthalmic services or to get reimbursements from supplementary insurance schemes. For example in the NHS of United Kingdom, co-payments exist for dental services. In Canada's Medicare, non-emergency dental care, eye care, medical appliances such as wheelchair and prosthesis are outside the federally funded Medicare, except for senior citizens, children and the indigent.

While a few such selected services may not be included, all other services, which would encompass practically all medically necessary services, would be included in many of the UHC systems.

12. Who provides services in a UHC system? Does the patient have to pay for services when they go to the doctor?

There are two dominant models of health care provision seen in UHC systems - public provision of services and public-private mixed provision of services. As would be expected, in each model the developed countries have on the whole been able to provide better coverage to a majority and developing countries are trying to do the same, though they may not have reached the same level of care. Following are descriptions of these models of health care.

- **Primarily public provision of services:** Most well functioning UHC systems have a significant component of public health provisioning. Further, in some UHC systems, much of the primary care and also the commonly required secondary care are provided free of cost by public dispensaries and hospitals e.g. Sri Lanka. In such systems where public provisioning is dominant, the private sector may be contracted in to provide services only where public services do not exist (e.g. specific areas), or for relatively less common problems (e.g. super-specialised services), or to provide tertiary care. They provide services on terms set by the public system, and under public regulation, thus effectively being an extension of the public system.

- **Public and Private mixed provision of services:** Many countries with UHC systems provide primary, secondary and tertiary care through a mixture of public and private providers. They have either a public or an autonomous, pro-people institution which decides the terms of purchase of services, fees for various services, standards of care and terms for provisioning services - thus regulating this system. In each geographical area some public and private facilities are designated for care and people are free to choose any one of these. These together form the UHC provisioning system.

In many countries having UHC, a small private sector completely outside the UHC system may continue to exist, which provides care for the elite based on private insurance, for example in Germany, Canada, Thailand, Brazil.

13. How is the UHC system regulated to prevent malpractices?

Countries have used various means to regulate the UHC system and its components. Following are some examples-

- **Legal and institutional regulation of UHC system:**

➢ In countries such as Canada, UK, Brazil and others which have legislation for UHC, the government needs to regularly report on the implementation.

➢ Most countries with UHC have designated agencies to decide on standards in health care, fee structure, and terms of purchase of services, incentives and disincentives to bring about optimum distribution of health care personnel and facilities. E.g. National Health Security Office (NHSO) of Thailand and the Inter-management commission and Health councils of Brazil.

- **Regulation of doctors, clinics and hospitals**

➢ In **Canada** limiting the use of private insurance or out-of-pocket payment for health care has been a major strategy of regulation because both of these operate for profit and hence encourage over-medication, unnecessary procedures and over-pricing. Here, about 95% of practitioners work with the UHC system, most hospitals are non-profit trust hospitals, and most provinces have explicitly banned use of private insurance for services covered by public insurance. Regular medical audits check for rationality of care, billing and malpractice.

➢ In **Thailand,** guarantee of care, without out-of-pocket payment through publicly contracted health care has been the

biggest safe-guard against pauperisation due to medical expenses. The contracted doctors, clinics and hospitals are paid on capitation basis, i.e. level of payment is based on number of persons for whom the facility is responsible. Payment is made in advance for a set of services per person as opposed to per-service reimbursement. This system discourages repeat visits and unnecessary procedures. The actual power to consumers in **Thailand** is 'voting with their feet'- i.e. opting to change the provider if services are not satisfactory. Patient activism has led to inclusion of Anti-retroviral therapy and Renal Replacement therapy under UHC.

➢ In **Brazil** prices for overall health care in contracted and state owned facilities, including salaries of personnel are fixed by the National Institute of Medical Care and Social Security. This helps in cost containment.

- **Distribution of health care personnel**

Canada has two medical colleges exclusively to educate doctors from rural areas, besides increased seats for rural students in other medical colleges. Canada, Brazil and Thailand provide incentive in the form of higher salaries, hardship allowances, increased fees for on-call duties etc for rural practitioners. Canada trains nurse practitioners and Brazil encourages generalist doctors rather than specialists, to increase availability of personnel in rural areas. Thailand has instituted compulsory rural service of 3 years for doctors, 4 years for nurses and 2 years for pharmacists to fill vacancies in rural areas. Thus these countries have made significant progress in optimal distribution of health care personnel, especially keeping in mind rural areas.

- **Cost containment of medicines**

Canada has a strong drug price control policy ensuring that prescription drug prices in Canada are consistently below the international average. Brazil has achieved notable success in

producing generic, non-patented ART (Anti-retroviral therapy for HIV/AIDS) medicines, notwithstanding opposition from pharmaceutical companies.

- **Participatory planning and accountability**

Brazil has set up Health councils at three levels- the National, State and Municipal levels with over 5000 such councils across the country. One-fourth of the health council members are from the government and public and private health care providers, one-fourth are representatives of health professionals and employees, while half is made up of health service users and consumers. The health councils are powerful bodies mandated with health policy implementation. Even the Inter-services Management Commissions responsible for management of the UHC systems report to the health councils at respective levels. This fosters collective planning, participation of consumers and accountability to consumers. Regularly held 'Health Conferences' where hundreds and even thousands of representatives of above mentioned groups meet and brain-storm at the National, State and Municipal levels have played an important role in shaping the UHC system in Brazil.

In this context, in India Community Based Monitoring and Planning (CBMP) of health services is an effort towards making health services accountable to community members while promoting their involvement in local planning processes. CBMP, a tool introduced as part of the NRHM on a pilot basis in certain districts of some states, enables ordinary people to audit health services for satisfactory performance; observed lacunae and people's expectations are then communicated to the health officials in public hearings or dialogues. Such experiences need to be built upon while devising accountability processes for a UHC system in the Indian context.

14. How have countries benefitted from improvement in health care coverage after UHC was adopted?

The major advantage of publicly funded UHC systems is that they do not exclude any diseases (e.g. HIV/AIDS) or conditions (e.g. pre-existing health problems) or any age groups (e.g. infants and the very old) from coverage, unlike private insurance schemes usually do. This has ensured greater equity in health care access.

Brazil: Access to primary health care has improved especially due to the Family Health Programme, coverage by this programme is highest in poorer areas and lowest in the wealthier regions, which indicates that services are reaching where most required[17]. As a result, Infant Mortality fell from 35 to 15 per 1000 live births between 1998 and 2006[18]. The universal access system of Brazil has been attributed with increase in life expectancy from 67 years in 1991 to 72 years in 2007. The unified health system has made it possible for all HIV patients to get ARV (Antiretroviral) treatment free of cost.

Thailand: Access to health care vastly improved in Thailand after the full fledged roll out of the UHC system. The percentage of uninsured went down from 55% in 1996 to 1.3% in 2004 - most of those covered later being from the poorest populations. 34% of beneficiaries of the Universal Scheme are in the poorest quintile (Q1) and another 26% in the poorer quintile (Q2). Out-patient visits increased from 29.7 million in 2001 to 63.8 million in 2004. Similarly admissions at district hospitals increased from 1.1 million (2001) to 2.2 million (2002).[19] Catastrophic health expenditure went down from 5.4% in pre universal coverage days to 2% in 2004. Impoverishment due to medical bills went down from 2.1% to 0.5.

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[17] Guanais, F. C. (2010). Health Equity in Brazil, British Medical Journal, Retrieved February 28, 2011, fromhttp://www.bmj.com/content/341/bmj.c6542.full.html.

[18] Ibid

[19] Khanna, R. (2010-11). Universal Health Coverage in Thailand: What Lessons Can India Learn?, MFC Bulletin, 342-44.

Maternal mortality is at relatively low level of 28 per 100,000 live births[20]. 92.9% of pregnant women could access four antenatal care visits and 98% women had deliveries with skilled attendance.

Sri Lanka: Sri Lanka's health indicators were worse than the rest of South Asia in the 1920s. The health reforms since 1930s not only bridged the gap but surpassed the other countries. Today the life expectancy in Sri Lanka today is 71 years, the infant mortality rate is 13 per thousand and maternal mortality ratio is the lowest in South Asia, many figures being comparable to developed countries[21].

15. What is NOT a system for 'Universal Health Care'?

In the above sections, we have tried to understand what constitutes a system for Universal Health Care. However, different experts and agencies have a different understanding of what is actually meant by a system for Universal Health Care or the similarly used term 'Universal Health Coverage'. This also leads to different benchmarks to define when a system for Universal Health Care is considered to have been achieved. Here we will clarify what is NOT a system for 'Universal Health Care', though there may be some superficial resemblance to it.

The Arogyasri Health Insurance scheme in Andhra Pradesh is being quoted as a major step towards 'Universal Health Coverage' (e.g. see report 'Catalysing Change' by Rockefeller Foundation, which devotes a chapter to presenting Arogyasri as a successful model of 'Universal Health Coverage'). This scheme provides government funded health care to patients below a particular income (constituting 80% of the population), enabling them to obtain only certain tertiary health services (particularly surgical care) from private providers on a cashless basis upto a limit of Rs. 1,5 lakh in a

[20] As compared to 294 per 100,000 figure of India.

[21] Rannan-Eliya, R. P., Sikurajapathy, L. (2009). Sri Lanka : 'Good Practice' in expanding health care, Colombo: Institute for Health Policy.

year (with a buffer of Rs. 50,000) for a family. This is a popular scheme which brought votes to the ruling party. But it is seriously deficient for the following reasons[22] –

1) This tertiary care is at the expense of increasing the budget and facilities for primary and secondary care in Public Health Facilities. Thus now bypass surgery can be done under this scheme but patients have to pay for treatment of say a simple fracture or a simple surgical condition not covered by the scheme, because good Public Facilities which can treat these conditions are few and far between. Thus majority of the even lower and lower middle class people are also induced to go to private hospitals for such conditions, even if their charges are unjustifiably high. This expense of even say Rs. 10,000 can push a poor family into a vicious, high interest private-loan for years.

2) The payment to private Hospitals is based on procedures they perform on the patients and not on diseases/conditions they treat. Thus in this scheme, hospitals are paid for bypass surgery, angioplasty, but not for treating ischaemic heart disease as such. This leads to a focus on opting for sophisticated surgical procedures rather than simple conservative measures, even if the latter are scientifically equally good. Sophisticated, costly surgical procedures like laparoscopic removal of appendix is preferred to conventional surgery. This scheme is made to primarily benefit the corporate hospitals and there is anecdotal evidence that patients are diverted from Public Health Facilities to the corporate hospitals empanelled in this scheme. The charges fixed for the procedures in this scheme are quite high. Till October 2011, the corporate hospitals in this scheme earned Rs. 2683 crores at an average bill of Rs. 28,455 per procedure. But people do not know about these charges and even if they do, they are generally not bothered since the Government pays for it.

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[22] Shukla, R., Shatrugna, V., Srivatsan, R. (2011). Aarogyasri Healthcare model: Advantage Private Sector. Economic and Political Weekly, 46 (49), 38-42.

Similar schemes have been initiated and are now in various stages of implementation in Tamil Nadu, Karnataka and Maharashtra. Keeping this in mind, there are several pitfalls to be guarded against, avoiding directions which do NOT constitute System for Universal Health Care. We may keep in mind -

- Mere provision of an insurance based financing mechanism for health care does not constitute a system for Universal Health Care. Just providing subsidised insurance cover, while letting the health care system continue to function in an unregulated manner without rational care guidelines, rational fee structure, minimum standards, grievance redressal, treatment based on essential drugs and other criteria mentioned in principles (question no 5) may not be sufficient to develop a system for Universal Health Care.

- Providing selective tertiary health care as seen in Arogyasri instead of a comprehensive set of primary, secondary and tertiary services, cannot be considered a system for Universal Health Care.

- Providing overall inadequate public finances for health care, with a targeted care package effectively catering only to 'BPL' section of the population does not constitute a system for Universal Health Care.

16. Above we have mostly discussed about access to health care. Would that be sufficient to ensure better health for people?

In question 3 above we have discussed the importance of ensuring ***social determinants of health***, which are essential but fall beyond the scope of Universal Health Care. UHC is only one of the determinants of the health of a population. While demanding a system for Universal Health Care, one must be aware of the risk of a highly medicalised model of care.

A medicalised approach to health care would only look at ways to provide the latest health care technology to all, but may not intervene in the processes which generate ill-health. For example

such a medicalised approach may provide a vaccine for cholera but will not advocate for improving water supply and sanitation. Such a system may treat illnesses among under-nourished children, but will do little to influence policies responsible for undernutrition. Thus the path of development which breeds ill-health would continue to lead to high morbidity and hence health care costs would keep increasing. This makes such a system more and more expensive. In such a situation, consumers' demand for the latest health-care technology would keep mounting, especially when the elite are able to access it by private means.

To avoid such a situation, and as a strategy to move towards a healthy development model, it is important that along with the UHC system, the government must also ensure complementary investment in disease preventive and health promoting measures. An example is the health promotion approach pioneered by Canada[23]. In 1978 Canada established the 'Federal Health Promotion Directorate' and mooted health promotion as a key strategy to improve the health of Canadians. The main thrust was on -

- establishing health promotion units in all provinces
- rapid growth in programmes encouraging positive life style changes through health education and social marketing
- development of community initiatives for improved nutrition, containment of non-communicable diseases, control of tobacco, alcohol and drug consumption and other public health issues
- improved funding for health promotion initiatives for women and vulnerable groups

This approach has improved the feasibility and sustainability of the Canadian UHC.

[23] Health Promotion in Canada, A case study. (1998). Health Promotion International, 13 (1), 7-26. Retrieved http://www.phac-aspc.gc.ca/ph-sp/pdf/hprpt-eng.pdf.

Keeping such a context in mind, a successful UHC system must be accompanied by -

➢ A strong, simultaneous emphasis on promoting social determinants of health and taking measures to secure all requirements for healthy living, which includes among other things clean and adequate drinking water, nutrition and food security, adequate housing and healthy environment.

➢ Promotion of rational self care and home care, healthy local traditions and positive lifestyle changes, while countering over-medicalisation of people's health. Sustained campaigns combined with regulation are required to minimise use of health-destroying products like tobacco, alcohol and addictive drugs

➢ Detecting and tackling health damaging factors such as contaminated water or hazardous industries through public regulation combined with community action

➢ Making strong investment in appropriate research and taking specific measures to break recurrent cycles of illnesses e.g. water borne illnesses, vector borne illnesses, cancers, pollutant linked illnesses, occupational health problems etc.

➢ Ensuring that ordinary people, including marginalised sections, come to the centre of the UHC system - both as recipients and decision makers.

17. What would be a more suitable model for financing such a system in India? How can the government raise the necessary scale of funds?

As mentioned above, tax based UHC systems are known to be most equitable, efficient and sustainable, for example UK, Brazil, Thailand and Sri Lanka. Hence India must strive for general as well as specific taxation to fund the UHC. The government is already committed to increasing health care expenditure to 3% of GDP. This can be augmented by ending subsidies to the commercial private medical sector, and with imposing a health cess on health

damaging industries such as tobacco, alcohol and polluting industries. Whatever may be the source of taxation, a larger proportion of funds should come from the central kitty. This might be supplemented by Social Health Insurance for the organised sector and tax payers, but all funds should be integrated in a single pool with a single payer mechanism.

18. Why do some countries have UHC systems while others do not? What is the role of political will in ensuring UHC systems?

It is true that among countries with similar income levels and democratic governance, some have been able to institute UHC systems while others such as India have not been able to. The level of political will and strength of pro-people political forces plays an important role in ensuring UHC.

For example, in Canada, the process of developing UHC was a highly political one. Tommy Douglas, a Baptist minister joined politics in the backdrop of the agrarian crisis leading to unemployment and widespread poverty during the 1930s in Saskatchewan province. He worked together with other clergymen, teachers, trade union workers and cooperative organisers to promote free medical care along with socially owned and democratically managed means of production, distribution and exchange. In 1962, as premier of the Saskatchewan province he implemented Canada's first compulsory medical care programme amid a lot of opposition from doctors[24] [25]. This further became the basis for a countrywide UHC system. Among the other countries who began the process for

[24] Guenther, B. L. (2000). Populism, Politics and Christianity in Western Canada, Historical papers: Canadian Society of Church History. 93-112.

[25] Ethan, C. (2011). Universal Health Care and Social Freedom, A Canadian's perspective on the political philosophy driving the American healthcare debate. Counterpoint. Retrieved http://www.counterpointmagazine.org/2011/03/25/universal-healthcare-and-social-freedom.

UHC early on, the push came from the workers' movements for better social security (e.g. Austria and Japan). While many countries were forced to acknowledge the need for social welfare measures (e.g Belgium), others such as Germany took steps in order to counter the rising political power of the organised workers[26].

More recently in Thailand, UHC became an important issue for campaigning in the 2000 elections for the Thai-Rak-Thai party. Simultaneous campaign by NGOs, an aware bureaucracy, competent health researchers, along with availability of trained human resources and public health infrastructure all played an important role in formulating the UHC system, but the primary agenda setting was done by the Thai-Rak-Thai party. This gave the party resounding success in the elections and also ensured smooth transition to universal coverage[27].

Another example is of Brazil, where social movements emerged in the context of overthrow of dictatorship, and resulted in a new constitution where UHC found its rightful place in the framework for social security. The new political establishment gave strong emphasis on UHC in its vision of pro-people politics[28].

There is today ample evidence about the hardships, impoverishment and misery to millions of people in India on account of inadequate access to health care. What is lacking is a strong demand for a system of Universal Health Care from organised groups and political parties. It is important that we work

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[26] Carrin, G., & James C., (2005). Social Health Insurance: Key factors affecting the transition towards universal coverage, International Social Security Review, 58(1).

[27] Tangcharoensathien, V., Prakongsai, P. et al. (2005). Achieving Universal Coverage in Thailand: What lessons do we learn? A case study commissioned by the Health Systems Knowledge Network.

[28] Scott, K. (2011). Understanding the Canadian, Thai and Brazilian universal healthcare systems: a focus on regulation and lessons for India. Medico Friend Circle Bulletin.

for inclusion of UHC as basic social security in the election manifestos of political parties. ***We also need better awareness of health care as a right among the people and various mass organisations and trade unions, so that UHC comes squarely onto the political agenda.***

19. Can this become a reality for India? Has there been any attempt to advocate UHC in India?

UHC can certainly become a reality in India. As we have seen above even relatively small Asian countries - Sri Lanka, Thailand, Republic of Korea and others have been able to provide UHC to their residents and have shown that it is feasible. Right to health care is an important social security provision, and its universal availability should become a norm in any democracy. Therefore it is high time for India to design and adopt a system for Universal Health Care.

Yes, there was an attempt earlier to plan for Health Care for All. On the verge of achieving independence from colonial rule, influenced by the experiences of social democratic countries and the new National Health System of UK, the Bhore Committee had recommended provision of comprehensive health services to all irrespective of the ability to pay. However this recommendation was not implemented fully, even though there was substantial expansion of Public Health Services, especially in rural areas. But on the whole, there has been progressive privatization of health care in India during last 60 years after independence.

It has been mentioned earlier that the Jan Swasthya Abhiyan (JSA), since it's inception in 2000 has been demanding Health Care for All, as part of it's goal of Health for All. Secondly, due to the logic of the election politics in the current era, under the current UPA government the Planning Commission instituted a 'High Level Expert Group' (HLEG) to give detailed recommendations for achieving UHC in India by 2020. It's report has to be considered

while formulating the 12th Five Year plan. This has provided us an important political space to campaign for a system for UHC in India. The HLEG has met various public health activists and groups while drafting its report. It is up to all of us to ensure that the pro-people recommendations of this committee are followed up with broader social demands and political action towards a system for UHC.

The Medico Friend Circle (a group of socially oriented health activists and experts working for the last 38 years with a pro-people perspective) has organised National meets on Universal access to Health care for three consecutive years in 2010, 2011 and 2012. Several of the above issues were discussed and these 'Frequently Asked Questions' draw upon many of those valuable discussions. These meetings and various debates have begun the process of building a social consensus towards a vision for UHC in India. In the background of all these developments, this is an opportune time to launch a national campaign on Universal health care / Health Care for ALL.

20. What can we do to further this demand and ensure UHC in India? What would be some of the first steps and social-political efforts required to move towards such a system in India?

Indeed all of us can contribute to making UHC a reality in India. Those of us who are part of organised groups such as Trade Unions, mass organisations, NGOs or political groups can ensure that UHC becomes a demand from all of these groups. A well thought out system of UHC should become the demand as against ill-designed, populist medical insurance schemes and outsourcing type 'Public-Private Partnerships' which become a rallying point in elections. Trade Unions and organisations of unorganised sector workers can discuss and contribute how the ESIS (Employees State Insurance Scheme) can become a part and may be improved and upgraded for inclusion in the UHC. Activists working among women, adivasis, dalits, people living with HIV/AIDS, sexual

minorities, other socially vulnerable groups, and those working on disability rights, mental health and similar neglected issues can discuss how their demands could be addressed in a universal system, while strongly promoting such a system for all. Whatever system is proposed must take care of the needs and rights of all these groups. An umbrella legislation or policy document has to be pursued which will delineate the principles for the UHC. The plan for UHC must be discussed and debated in a transparent manner before it is taken up for implementation.

A wider, national debate about the exact nature of the changes that would be brought about to reach the declared goal of UHC in India is very much necessary also because of certain new developments in 2012. The Report of the Steering Committee on Health for the 12 Five Year Plan, published in March 2012 has taken some very problematic positions. For example, in section 1.6.4 on page 14, this report says *"In order to spur competition and make providers responsive, beneficiary families should be provided a choice to opt for a health provider from a panel of public, private and not-for profit providers. All providers should be incentivized on the basis of their contribution to health outcomes, to be monitored by the proposed Health Information System (HIS). Public health care facilities should be provided financial and operational autonomy so that they are able to compete with private and Non-Governmental Organization (NGO) providers.-----."*

HLEG recommendation 3.1.10 as formulated in the Executive Summary of it's report also creates some ground for this above position. This recommendation 3.1.10 in the Executive Summary says *"State governments should consider experimenting with arrangements where the state and district purchase care from an integrated network of combined primary, secondary and tertiary care providers. These provider networks should be regulated by the government so that they meet the rules and requirements for delivering cost effective, accountable and quality healthcare. Such an integrated provider entity should receive funds to achieve negotiated predetermined health outcomes for the population being covered. This entity would bear financial risks and rewards and be required to deliver on healthcare and wellness objectives."*

Instead of moving along the path of progressive socialization of health care in India through strengthening of the Public Health Services, this position would foster the process in opposite direction, i.e. it would pave the way for further privatization. If we want progressive socialization of health care in India through strengthening of the Public Health Services, there can not be any question of PHSs competing with the private sector or PHSs adopting the same objectives as that of the private sector. Financial autonomy for Public Health Facilities (PHFs) would mean 'generating their own revenue', for which the PHFs would have to follow the 'logic of the market' of making money.

Given this background, we certainly need to carry out a broader debate about the content of the system of UHC and the roadmap to reach this goal.

Some first steps can be taken in the immediate future, which would pave the way for a system for UHC in India:

- **Significantly strengthen the Public Health System while making it accountable:** Currently the public system caters to only about one-fourth of health care needs. It is also perceived to be bureaucratic, corrupt, non-responsive to people's needs. In order that the public system becomes the back-bone of the UHC, it needs to be strengthened, expanded with infusion of funds, infrastructure and human power. Simultaneously it needs to be democratised from within and it's functioning has to become more effective, sensitive, transparent and accountable to people through measures such as Community Based Monitoring and Planning.

- **Regulate and Harness Private Medical Providers:** Private hospitals, nursing homes and other clinical establishments need to be standardised to ensure minimum standards of care, rationality of care, reasonable fees, patients' rights and a grievance redressal mechanism. Towards this, standard guidelines for quality of care, treatment protocols and rational cost estimates of common health care services need to be developed. The Mumbai High Court judgement mandating that all Trust hospitals must reserve 20% of

beds for economically weaker sections and creation of an indigent patient fund should be fully implemented, extended and similar provisions should be ensured nationally.

• **Reorganise Public Health Insurance and ensure coverage for all unorganised sector workers:** The existing ESIS clinics and hospital network, which is generally under-utilised should be opened up for informal sector workers. Various social health insurance schemes such as ESIS, Rashtriya Swasthya Bima Yojana (RSBY) and others may be integrated and effectively regulated so that the private sector does not misuse them; these should be further merged or subsumed under the UHC system.

• **Substantially increase public health financing:** India is already committed to increasing health financing to 3% of GDP from the current level of 1.1%. This implies a quantum jump in health care budget, a large part of which should be utilised for strengthening of the public health system.

• **Ensuring laws and governance for the health system:** Enactment of a National Health Act which ensures right to health and health care for all is an important legal step. Community Based Monitoring should be extended to ensure participatory planning and monitoring of all health services, with active involvement of civil society organisations. Generating widespread awareness and people's organisation for health rights is an essential condition to make any UHC system successfully work in people's interests.

The above 20 questions and answers would give an overall idea about Health Care for All / a system for UHC and how this goal can be achieved in India. It would be clear that in the 21st century, health care should be considered a human right, and for people, health care should cease to be a commodity. Despite the growth of the Public Health System after Independence, the health care system in India is on the whole today geared to the logic of the market in health care. It

is now more than high time that it should be transformed into a system which is geared to the logic of Social Medicine even though certain, regulated private providers would continue to have a role in the Indian UHC system. This transformation into a system which is geared to fulfil the health rights of all the residents in India is a stupendous challenge and would require extensive social churning – it is high time that we all rise to meet this challenge and convert the dream of universal health care into reality.

For further discussion and views on UHC see -

1. *HLEG report on UHC- http://www.phfi.org/images/what_we_do/HLEG_Report_complete_file_final.pdf*
2. *The MFC meet background papers – http://www.mfcindia.*
3. *http://www.phm-india.org*
4. *Universal Access to Healthcare: Threats and Opportunities Anil Gupta and others, Economic & Political Weekly EPW June 25, 2011 vol xlvi nos 26, 27*
5. *The Lancet series (Vol 377, Issue 9765, 2010) – http://www.thelancet.com /series/india-towards -universalhealth-coverage*

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Recommendations of the High Level Expert Group (HLEG) on UHC and Key Issues Concerning these Recommendations

HLEG Recommendations

3.1 Health Financing and Financial Protection

3.1.1: Government (Central government and states combined) should increase public expenditures on health from the current level of 1.2% of GDP to at least 2.5% by the end of the 12th plan, and to at least 3% of GDP by 2022.

3.1.2: Ensure availability of free essential medicines by increasing public spending on drug procurement.

3.1.3: Use general taxation as the principal source of health care financing – complemented by additional mandatory deductions for health care from salaried individuals and tax payers, either as a proportion of taxable income or as a proportion of salary.

3.1.4: Do not levy sector-specific taxes for financing.

3.1.5: Do not levy fees of any kind for use of health care services under the UHC.

3.1.6: Introduce specific purpose transfers to equalize the levels of per capita public spending on health across different states as a way to offset the general impediments to resource mobilisation faced by many states and to ensure that all citizens have an entitlement to the same level of essential health care.

3.1.7: Accept flexible and differential norms for allocating finances so that states can respond better to the physical, socio-cultural and other differentials and diversities across districts.

3.1.8: Expenditures on primary healthcare, including general health information and promotion, curative services at the primary

level, screening for risk factors at the population level and cost effective treatment, targated towards specific risk factors, should account for at least 70% of all healthcare expenditure.

3.1.9: Do not use insurance companies or any other independent agents to purchase health care services on behalf of the government.

3.1.10: Purchases of all health care services under the UHC system should be undertaken either directly by the Central and state governments through their Departments of Health or by quasi-governmental autonomous agencies established for the purpose.

3.1.11: All government funded insurance schemes should, over time, be integrated with the UHC system. All health insurance cards should, in due course, be replaced by National Health Entitlement Cards. The technical and other capacities developed by the Ministry of Labour for the RSBY should be leveraged as the core of UHC operations – and transferred to the Ministry of Health and Family Welfare.

3.2 Health Service Norms

3.2.1: Develop a National Health Package that offers, as part of the entitlement of every citizen, essential health services at different levels of the health care delivery system.

3.2.2: Develop effective contracting-in guidelines with adequate checks and balances for the provision of health care by the formal private sector.

3.2.3: Reorient health care provision to focus significantly on primary health care.

3.2.4: Strengthen District Hospitals.

3.2.5: Ensure equitable access to functional beds for guaranteeing secondary and tertiary care.

3.2.6: Ensure adherence to quality assurance standards in the provision of health care at all levels of service delivery.

3.2.7: Ensure equitable access to health facilities in urban areas by

rationalizing services and focusing particularly on the health needs of the urban poor.

3.3 Human Resources for Health

3.3.1: Ensure adequate numbers of trained health care providers and technical health care workers at different levels by a) giving primacy to the provision of primary health care b) increasing HRH density to achieve WHO norms of at least 23 health workers (doctors, nurses, and midwives).

3.3.2: Enhance the quality of HRH education and training by introducing competency-based, health system-connected curricula and continuous education.

3.3.3: Invest in additional educational institutions to produce and train the requisite health workforce.

3.3.4: Establish District Health Knowledge Institutes (DHKIs).

3.3.5: Strengthen existing State and Regional Institutes of Family Welfare and selectively develop Regional Faculty Development Centres to enhance the availability of adequately trained faculty and faculty-sharing across institutions.

3.3.6: Establish a dedicated training system for Community Health Workers

3.3.7: Establish State Health Science Universities.

3.3.8: Establish the National Council for Human Resources in Health (NCHRH).

3.4 Community Participation and Citizen Engagement

3.4.1: Transform existing Village Health Committees (or Health and Sanitation Committees) into participatory Health Councils.

3.4.2: Organise regular Health Assemblies.

3.4.3: Enhance the role of elected representatives as well as Panchayati Raj institutions (in rural areas) and local bodies (in urban areas).

3.4.4: Strengthen the role of civil society and non-governmental organisations.

3.4.5: Institute a formal grievance redressal mechanism at the block level.

3.5 Access to Medicines, Vaccines and Technology

3.5.1: Enforce price controls and price regulation especially on essential drugs.

3.5.2: Revise and expand the Essential Drugs List.

3.5.3: Strengthen the public sector to protect the capacity of domestic drug and vaccines industry to meet national needs.

3.5.4: Ensure the rational use of drugs.

3.5.5: Set up national and state drug supply logistics corporations.

3.5.6: Protect the safeguards provided by the Indian patents law and the TRIPS Agreement against the country's ability to produce essential drugs.

3.5.7: Empower the Ministry of Health and Family Welfare to strengthen the drug regulatory system.

3.6 Management and Institutional Reforms

3.6.1: Introduce All India and state level Public Health Service Cadres and a specialized state level Health Systems Management Cadre in order to give greater attention to public health and also strengthen the management of the UHC system.

3.6.2: Adopt better human resource practices to improve recruitment, retention motivation and performance; rationalize pay and incentives; and assure career tracks for competency-based professional advancement.

3.6.3: Develop a national health information technology network based on uniform standards to ensure interoperability between all health care stakeholders.

3.6.4: Ensure strong linkages and synergies between management and regulatory reforms and ensure accountability to patients and

communities.

3.6.5: Establish financing and budgeting systems to streamline fund flow.

3.6.6: We recommend the establishment of the following agencies:

National Health Regulatory and Development Authority (NHRDA)

National Health Drug Regulatory and Development Authority (NDRDA)

National Health Promotion and Protection Trust (NHPPT)

3.6.7: Invest in health sciences research and innovation to inform policy, programmes and to develop feasible solutions.

Key Issues Concerning HLEG Recommendations

Features to be welcomed in HLEG's recommendations:

Unlike the dominant international discourse on UHC, the HLEG has not focused only on financial measures to achieve Universal Health Coverage, but has also recommended a whole series of measures which imply fair amount of changes in the existing health care system. The features to be welcomed in HLEG's recommendations are as follows:

- *The emphasis of the report on the concept of "universal" over the earlier dominant "selective" or "cost- effective" package.*
- *Clear emphasis on tax-based financing of the health system.*
- *The complete rejection of user fees in the health system.*
- *Definite commitment to "Free Medicines for ALL" in the Public Health System.*
- *The call to enforce price regulation and apply price control on all formulations in the Essential Drug List.*
- *Strengthening of public sector vaccine production capacity and protecting indigenous capacity even in the private sector.*

- *The Call to protect the safeguards provided by the Indian patents law and the TRIPs and protect the country's ability to produce essential drugs.*
- *Bringing focus to the critical issue of human resources to the center of the table.*
- *The suggestions for the strengthening and the expansion of the public sector and the earmarking of the necessary budget, and especially the establishment of an Urban UHC system.*
- *Clear statement against the use of private insurance in the financing of health care.*
- *Defining the need and urgency of private sector regulation, as well as outlining a regulatory structure.*
- *Bringing Community based accountability mechanisms to the center stage.*
- *The suggestion of a redressal mechanism.*
- *Transfer the Department of Pharmaceuticals to the Ministry of Health.*

Crucial gaps in the HLEG report:

- ***Shift from the discourse of the Alma Ata Declaration*** to the discourse of Universal Health Coverage
- ***No deeper engagement with state level implementers*** in the public sector
- ***No substantive critique of the rapidly growing, unregulated private health system***, especially the emergence of the corporate health care as a dominant entity in the last two decades,
- ***No categorical emphasis on*** priority for strengthening the Public Health System
- ***Absence of detailed rationale,*** of some of the key recommendations, (though the timeframe available to the HLEG was very tight) –
  - Scale of health care financing required for UHC (2.5% of GDP),
  - Funds required for 'Medicines for All'- 0.5% of GDP – 30,000 crores

- 70% of funds to be earmarked for Primary Health Care,
- Package of Essential Health Services – the table in the HLEG report which gives the 'core package' consists of only Reproductive and Child Health Services plus existing National Programmes

- The suggestion about the ***National Health Entitlement Card.*** This card can lead to *denial of health care as it is likely to become a pre-condition for accessing health care under UHC.*
- No detailed recommendations to address this challenge of ***social determinants of health,*** though it is welcome that the HLEG decided to take up the issue of, even though it was not part of it's mandate. This lacunae is because of the departure from ***discourse of the Alma Ata Declaration***
- No specific recommendations to address the current ***neglect of health care for women***, especially as regards reproductive, sexual health. The gender concern in this report effectively becomes a post-script.

Concluding Section of JSA Statement on Universal Health Care

We welcome the national attention and emerging policy level commitment to health care, in this situation Jan Swasthya Abhiyan calls for the following:

- A ***national public debate*** on the contours of the proposed universal health care system. Such an important issue cannot be rushed through and its various strands need to be understood, discussed and commented upon widely by the people.
- Definition of a clear, transparent and time bound ***road map for strengthening and expanding the public health system*** while improving its functioning and accountability; this must include allocation of adequate, enhanced budgets.
- Enactment of adequate ***laws guaranteeing the right to health***, including National and State Health acts, which would lay down

the ***framework for regulation of the health system***, particularly relevant for private medical providers. Providing entitlements must be accompanied by a ***clear framework for accountability and grievance redressal.***

- While developing and operationalising the universal health care system, ***highest priority must be given to significant expansion and improvement of public health services.*** Regulated private providers should not be competing with public providers for common resources, rather they may be in-sourced to provide services, but never as a substitute to the public sector.
- ***Ensuring forums for participation*** of community members, community based groups and civil society organizations along with elected representatives and public health functionaries at various levels, ***for planning, monitoring and reviewing*** the functioning of the universal health care system.
- Organizing a process of ***mapping and estimating the pattern of health care services required in each district*** and within each district in areas with special needs. This process must be transparent and widely discussed by people in each district.

We must be aware that the direction of developing universal health care in India must be towards ***strengthening the public health system and socialization of health care, rather than promoting further expansion of unregulated, profit-oriented private medical care.*** Hence a national debate is essential and there should be no haste in rolling out these concepts – even the looming large of the General elections should not become an excuse for the government to short circuit and distort the concept of Universal Health Care for narrow political gains.

(JSA NATIONAL WORKING GROUP)

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Twenty Questions and Answers about A System for Universal Health Care What is it? How can we hope to achieve it?

This booklet answers 20 key questions on Universal Health Care (UHC). It explains how good quality, appropriate Health Care which is free at the point of service, can be made available to everybody in India within the coming decade or so.

This booklet first explains basic concepts like what is exactly meant by Universal Health Care; what are the core principles of UHC etc.

It then turns to the experiences of various countries including some developing countries of moving towards the goal of UHC and basic requirements as regards financing, provisioning, governance, which have to be fulfilled to realize the goal of UHC.

Lastly, the booklet discusses the specificities of the Indian situation, including the need to strengthen, expand the Public Health System and to regulate the private providers. This last section also discusses the first steps that need to be taken in face of the huge challenges we face in India along the road to 'Health Care for All', which is part of the larger goal of 'Health for All'.

Various pro-people bodies working on health issues like Jan Swasthya Abhiyan have been advocating since 2000, 'Health and Health Care for All' in India. Now Universal Health Care has begun to figure in the official agenda. Perhaps as a preparation for the next Lok Sabha election in 2014, the Prime Minister's Office fostered the appointment of a 'High Level Expert Group' (HLEG) by the Planning Commission to prepare a 'blueprint' for achieving Universal Health Coverage in India by 2020. It's report is being considered for formulating the 12th Five Year plan and a number of debatable issues are emerging. With Universal Health Care developing into an important national issue, this booklet would be of interest to a wide audience, including health activists, health professionals, researchers, trade unionists, journalists and social-political activists.

SATHI Publication Contributory price Rs.40/-